
# QUALITY COMPANION GUIDE
# MANAGED CARE ORGANIZATIONS

**Prepared on Behalf of**

## State of Louisiana
## Department of Health and Hospitals

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## Quality Companion Guide Table of Contents

# SECTION 1: INTRODUCTION

## Quality Companion Guide Purpose

The Quality Companion Guide focuses on core quality improvement activities, assisting Managed Care Organizations (MCOs) with Department of Health and Hospitals (DHH) contract requirements and External Quality Review Organization (EQRO) activities and processes. The timeframes provided for each activity may be modified at the discretion of DHH.

## External Quality Review (EQR) Regulations

Title 42 (Public Health) of the Federal Code of Regulations, Part 438 (Managed Care), Subpart E details CMS's requirements for the conduct of annual external quality reviews of each MCO. (The Code of Federal Regulations is available at http://www.gpoaccess.gov/ecfr/). Subpart E is broad in scope, addressing such topics as state responsibilities, protocols for conducting EQR, qualifications of EQROs, state contract options, non-duplication of mandatory activities, exemption from external quality review, and federal financial participation.

## EQR-Related Activities

Section §438.358 specifies the mandatory and optional EQR-related activities, listed in the table below.

| | |
|---|---|
| Validation of performance improvement projects | Mandatory |
| Validation of performance measures | Mandatory |
| Review to determine plan compliance with structure and operations standards | Mandatory |
| Validation of encounter data | Optional |
| Administration or validation of consumer or provider surveys of quality of care | Optional |
| Calculation of performance measures | Optional |
| Conduct of performance improvement projects | Optional |
| Conduct of studies on quality that focus on a particular aspect of clinical or non-clinical services | Optional |

Although a single EQRO conducts the overall EQR, States may conduct individual ERQ-related activities themselves or contract with other organizations to conduct EQR-related activities. If other entities conduct EQR-related activities, the State must provide the EQRO with the data generated from each of the EQR-related activities for analysis in the EQR.

DHH has contracted with the accounting firm, Myers & Stauffer, L.C. (MSLC) to conduct the EQR activity "validation of encounter data." IPRO will include information obtained from MSLC in each MCO's annual technical report.

CMS provides protocols for conducting each of the mandatory activities, which are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. States and EQROs are not required to use

the CMS protocols in conducting EQR-related activities, but must use protocols that are consistent with the CMS protocols.

In addition to conducting the mandatory and optional activities listed in the table, the State may also direct the EQRO to provide technical assistance to MCOs to assist them in conducting these activities.

## EQR Annual Reporting Requirements

Section §438.364 requires that all the mandatory and optional activities specified in §438.358 must be described in an annual detailed technical report, including information regarding the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data. Also required is an assessment of strengths and weaknesses for each health plan, as well as recommendations for improvement and an assessment of whether each health plan has acted on recommendations for quality improvement made by the EQRO during the previous year's EQR.

## Louisiana Medicaid Managed Care EQR Overview

The Louisiana EQR contract with IPRO was renewed September 2014. A brief description of each IPRO deliverable under this contract's scope of work follows:

***Readiness Reviews -*** Develop a Louisiana-specific readiness review tool and methodology. Evaluate each MCO's operational capacity to participate in Medicaid managed care and begin enrollment. Determine if each MCO can demonstrate an accessible provider network within its service area and the ability to operate a program that will meet DHH requirements.

***Compliance Reviews –*** Develop a Louisiana-specific compliance review tool and methodology. Assess each MCO's compliance with federal and state managed care regulations and with DHH contract requirements.

***Performance Improvement Project (PIP) Validation -*** Present the PIP reporting method through a timeline and instructions, assess MCO methodology for conducting PIPs, verify PIP study findings, evaluate overall validity and reliability of PIP study results, and evaluate the success of interventions to improve quality of care.

***Performance Measure Validation -*** For the DHH-selected performance measures, present the measures and the reporting method through a timeline and instructions, evaluate data accuracy via source code and data validation activities, calculate the results, and obtain MCO agreement.

***Technical Report -*** Produce annual Technical Reports that assess the MCOs' performance, in compliance with the requirements of 42 CFR §438.364 and Louisiana State specifications. Prepare a report for each MCO..

***Medical Loss Ratio (MLR) Recommendations -*** Assess compliance with the MCO MLR policy, review the activities that the MCOs assert are quality related and make written recommendations as to whether the activities meet criteria to be classified as quality expenditures.

***Quality Companion Guide -*** Develop a written document to assist MCOs in carrying out quality improvement activities including background information on EQR regulations and the role of the EQRO and instructions and timelines related to readiness review, annual compliance review, PIP validation and PM validation.

***Focused Studies-*** Design and conduct at least two focused studies to evaluate the quality of clinical and/or nonclinical services at a point in time, as determined by the state. IPRO will collaborate with DHH to ensure alignment of study topics and objectives with state priorities, goals and initiatives.

***Provider Surveys-*** One statewide provider survey will be designed and implemented per year. Through provider surveys, DHH can evaluate the experience of specific types of providers in the Medicaid managed care program, the effectiveness of certain managed care or Medicaid programs, and/or how satisfied Medicaid providers are with a particular aspect of an MCO's performance.

# SECTION 2: READINESS REVIEW

## Process Overview

Readiness reviews evaluate Louisiana Managed Care Organizations' (MCOs') operational capacity to participate in Medicaid managed care and commence enrollment. The MCOs are required to demonstrate the ability to operate a program that meets the Department of Health and Hospitals' (DHH) requirements and are expected to clearly define and document the policies and procedures to support day-to-day business activities related to Louisiana Medicaid enrollees.

## Task Description

As the Louisiana External Quality Review Organization, IPRO readiness review activity focuses on policies, procedures and other documentation related to MCO operations including the following:

a) Operations activities in the contracted scope of work
b) Provider contracting and credentialing
c) Member Services staff and Provider training
d) Coordination with State contractors and with the MCO's subcontractors
e) Member Handbook
f) Provider Manual
g) Provider Directory
h) Member Identification Card
i) Member complaint and appeals processes
j) Toll-free telephone systems and reporting capabilities for members and providers
k) Fraud and Abuse Compliance Plan.

The readiness reviews are conducted in three phases: pre-onsite (desk review), onsite and post-onsite (reporting).

## Methodology

*Preparation of Readiness Review Tools:* IPRO prepares the readiness review tools for the following DHH requirements:

| DHH MCO Requirements (RFP Section) | |
|---|---|
| Scope of Work and General Requirements (2.0) | Utilization Management (9.0) |
| Eligibility (3.0) | Provider Reimbursement (10.0) |
| Staff Requirements and Support Services (4.0) | Provider Services (11.0) |
| MCO Reimbursement (5.0) | Enrollment and Disenrollment (12.0) |
| Core Benefits and Services (6.0) | Member Education and Marketing (13.0) |
| Care Management (7.0) | Member Grievance and Appeals Procedures (14.0) |
| Provider Network Requirements (8.0) | Quality Management (15.0) |
| Appointment Accessibility Standards (8.2) | Fraud, Abuse and Waste Prevention (16.0) |

*Scoring Criteria:* Each individual DHH **requirement** is scored individually and on a three-point scale as follows:

- *Met* – the requirement is in full compliance
- *Not Met* –the requirement is not in full compliance
- *Not Applicable* – the requirement is not applicable to the MCO

Some requirements may include a file review to verify compliance (e.g., provider contracts). File reviews are performed during the onsite visit.

*Schedule Onsite Reviews:* IPRO contacts each MCO to schedule the onsite reviews. Onsite reviews are conducted at the MCO offices.

*Training Webinar/Conference Call:* Prior to the readiness reviews, IPRO conducts an orientation session for the MCOs to introduce the IPRO Readiness Review Team and prepare the MCOs for the review. IPRO conducts a walk-through of the readiness review process and the review criteria, tools and documentation requirements. IPRO also presents the overall timeline for review activities and requirements for documentation submission and availability.

*Pre-Onsite Documentation:* IPRO prepares and submits a Document Submission Guide, Submission Forms, and FTP instructions to the MCOs.

## Desk Review

During the desk review, each area is reviewed considering the supportive documentation submitted by the MCO. The desk review process is dependent on the MCO providing IPRO with all the appropriate documentation for each DHH requirement with the MCO's original submission.

The review process includes one desk review. As deemed appropriate, IPRO *may* request additional information prior to the onsite; however, the MCO should prepare for only one document submission opportunity.

## Onsite Review

Each onsite readiness review is completed in one day with additional teleconference time scheduled as necessary. The review begins with an opening conference during which IPRO presents an overview of the readiness review process and reviews the agenda for the visit. During the site visit, appropriate MCO managers and staff are interviewed in key areas, and relevant documentation is reviewed. The review concludes with a closing conference, during which IPRO provides feedback regarding preliminary findings.

## Reporting

IPRO provides DHH with a readiness review report generally within seven business days of the onsite. At DHH's discretion, IPRO distributes the MCO-specific findings to the respective MCOs. IPRO rates the MCO in each area as being "met" or "not met" (defined in table below). Two categories of concern are identified: major areas of concern that the MCO must address prior to initiation of enrollment, and minor areas of concern that need to be corrected by a specific date but do not have to be corrected prior to initiation of enrollment. It is the expectation that before plans begin operation, a "met" designation is required for each major area of concern.

| Designation | Description |
|---|---|
| **Met (Full Compliance)** | MCO has met or exceeded requirements. |
| **Not Met (Non-Compliance)** | MCO has not met the requirements. |
| **Not Applicable** | Requirement is not applicable. |

DHH makes all final decisions regarding MCO operational readiness.

| Task | Timeline |
|---|---|
| IPRO pre-onsite review (e.g. policies) | Late December-early January 2015 |
| Onsite review | January 2015 |
| IPRO completes post-onsite review and issues a readiness review report to the DHH | Late February-early March 2015 |
| Readiness review findings are distributed to the MCOs | Early/mid March 2015 |
| Readiness review of dental MCO | Start Date: March 2015 |

# SECTION 3: ANNUAL COMPLIANCE REVIEWS

## Process Overview

One of the mandatory activities for External Quality Review (EQR) is a review to determine an MCO's compliance with state and federal standards that comply with federal regulations at § 438.204 (g). This section includes standards related to Access, Structure and Operation, and Quality Assessment and Performance Improvement. In addition, these standards reference two other related sections - Enrollee Rights (438.10) and Grievance Systems (Subpart F). At the discretion of DHH, the EQRO may review all standards annually.

The CMS EQR regulations (438.360) allow for non-duplication of mandatory activities at the state's discretion. These regulations permit use of information about an MCO obtained from a private accreditation review if certain conditions are met. These conditions include, but are not limited to: the MCO is in compliance with the standards established by the national accrediting organization, and the organization's standards are comparable to the federal standards. For MCOs achieving accreditation, IPRO uses the toolkits produced by the accrediting organizations and the MCO-specific accreditation reports/results to identify standards which have been found to meet the federal and state regulatory requirements and includes the accrediting organization's results for those standards in the compliance review.

## Task Description

The Compliance Review determines MCO compliance with DHH contract requirements and with state and federal regulations in accordance with the requirements of § 438.204 (g). Each assessment includes a documentation review (desk audit), file reviews, MCO staff interviews, and, as appropriate, direct observation of key program areas. The assessment is completed in three phases:

Phase One – Pre-assessment activities (planning, preparation and desk audit)
Phase Two – Onsite assessment activities
Phase Three – Post-assessment activities (post-review follow up and report preparation)

## Methodology

Phase One: Pre-Assessment Activities
*Preparation of Assessment Tools and Worksheets:* IPRO prepares the assessment tools and worksheets for each standard.

Each of the tools is structured the same and includes: federal requirements, related federal requirements, state-specific contract requirements/standards, suggested evidence (this column forms the basis of the pre-onsite documentation and case listing requests, and includes relevant documents and reports), reviewer comments (to document findings related to any requirements that are not fully compliant), and prior results and follow-up (pre-populated with the prior year's

findings for any requirements that were less than fully compliant. In addition, corrective actions taken by the MCO in response to the prior year's findings are documented so the reviewer can validate their implementation).

Some standards/requirements require file reviews. Worksheets for each type of file review that will be used by the IPRO reviewers to document their findings are created.

*Scoring Criteria:* Each standard is rated as being in "Full Compliance," "Substantial Compliance", "Minimal Compliance" or "Non-Compliance" (defined in the table below).

| Designation | Description |
|---|---|
| **Full Compliance** | MCO has met or exceeded the standard. |
| **Substantial Compliance** | MCO has met most of requirements of the standard but has minor deficiencies. |
| **Minimal Compliance** | MCO has met some requirements of the standard, but has significant deficiencies requiring corrective action. |
| **Non-Compliance** | MCO has not met the standard. |

*Schedule Onsite Assessments:* IPRO contacts each MCO to schedule the onsite assessments. Onsite assessments are conducted at the MCO offices.

*Training Webinar/Conference Call:* IPRO provides a training session before the scheduled compliance reviews. The training includes a walkthrough of the assessment process, documentation requirements and timeline.

*Introductory Packet:* IPRO prepares and submits an Introductory Packet to the MCOs including:
- Confirmation of the dates for the assessment
- A detailed site visit agenda
- Identification of the Assessment Team Members
- Pre-onsite documentation request (all documents required for the compliance review will be requested)
- Request for listings of files eligible for review

*Select Random and/or Focused Samples:* Upon receipt of the eligible file lists from the MCOs, IPRO selects samples for review. MCOs are provided listings of the selected files via IPRO's secure FTP site.

*Review of Pre-onsite Documentation:* Prior to the onsite assessment, IPRO reviews the pre-onsite documentation submitted by the MCOs and documents findings using the assessment tools. As deemed appropriate, IPRO may request additional information prior to the onsite interview session.

Phase Two: Onsite Assessment Activities

*Opening Conference:* The onsite assessment begins with an opening conference, at which IPRO reviewers and MCO staff are introduced. During the opening, IPRO provides an overview

of the purpose of and process for the review and onsite agenda. The opening conference may also allow for a brief presentation by the MCOs to highlight any corporate changes or new initiatives.

*Onsite Review:* The onsite review is conducted in accordance with the onsite agenda previously shared with the MCO. The onsite agenda is tailored as necessary to accommodate MCO staff availability and/or the attendance of DHH staff. IPRO reviewers conduct the file reviews and face-to-face interviews with selected MCO staff members, to clarify and confirm findings. As appropriate, walkthroughs or demonstrations of work processes with key MCO staff are conducted.

*Closing Conference:* The onsite review concludes with a closing conference, during which IPRO provides feedback regarding preliminary findings and presents the next steps in the review process.

Phase Three: Post-Assessment Activities

*Preliminary Findings:* Upon completion of the onsite assessment, IPRO reviewers complete the assessment tools, and assign scoring designations to each standard/requirement. Preliminary findings are submitted to DHH for review.

*Final Findings:* At DHH's direction, IPRO distributes the MCO-specific findings to the respective MCOs.

*QI Action Plan:* A QI Action Plan is requested from MCOs for all areas that score Minimal or Non-compliance. A QI action plan form and submission instructions are provided. IPRO, in conjunction with DHH, will review and approve the action plan or request modifications. The action plan is validated during the next annual compliance review.

**Timeline**

| Task | Timeframe* |
|---|---|
| IPRO discusses with DHH the review methodology and obtains all necessary source documents | January-February of each project year |
| IPRO prepares and submits draft review methodology including review criteria, tools, crosswalk of standards eligible for deeming and pre-onsite correspondence to DHH for review and approval | Early-mid June of each project year |
| IPRO finalizes review methodology based upon DHH feedback | Within 10 days of receipt of DHH Feedback (early July of each project year) |
| IPRO conducts review process orientation for MCO | Two months prior to scheduled review (late July-early August of each project year) |
| IPRO sends introductory communication and requests pre-onsite documentation including eligible file lists from MCO | Five to Six weeks prior to scheduled review (mid to late August of each project year) |
| IPRO provides list of selected files to MCO | Three to four weeks prior to review (mid-late September of each project year) |
| IPRO reviews pre-onsite documentation as submitted by MCO | Two-three weeks prior to review (early- mid October of each project year) |

| Task | Timeframe* |
|---|---|
| IPRO conducts onsite compliance review (opening conference, documentation review, interviews, observation, closing conference) | (Late October-early November of each project year) |
| IPRO prepares and submits annual compliance review report to DHH | Within 30 business days of completion of MCO onsite visit (December of each project year) |

*Approximate timeframes

# SECTION 4: PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

## Process Overview

One of the mandatory activities for External Quality Review (EQR) is to review PIPs for methodological soundness of design, conduct and reporting to ensure meaningful improvement in care, and confidence in the reported improvements.

### Task Description

PIPs promote MCO improvement in quality of care and outcomes for members. The CMS protocol for validating PIPs includes three major activities:

- Assessing the MCO's methodology for conducting the PIP;
- Verifying actual PIP study findings; and
- Evaluating overall validity and reliability of PIP study results.

MCOs are required to conduct a minimum of two DHH-approved PIPs each year. 2015 PIP topics are listed in Table 1 below.

***Table 1: Performance Improvement Projects (PIPs)***

| Contract Year | PIP Focus | Target for Improvement |
|---|---|---|
| 2015-2017 | **Prematurity -** Reduce premature births to Medicaid-eligible women. | • Reduce prematurity statewide by 15% by the end of the three-year contract period |
| 2015-2017 | **Attention Deficit and Hyperactivity Disorder (ADHD)** – Increase appropriate ADHD diagnosis and drug utilization. | • Reduce by 20% prescriptions among populations who are shown to have a high incidence of prescribing with a focus on the 0-6 population |

Within three months of the execution of the Contract and annually thereafter, the MCOs submit, in writing, a general and a detailed description of each PIP to IPRO on behalf of DHH for approval.

MCOs typically follow an approximate six month approach to collection of PIP baseline data and subsequent measurement of demonstrable improvement and measurement of sustained improvement. PIPs can be implemented early on as opposed to waiting for the MCOs to have a full year of service data.

With this approach, IPRO validates PIPs in a manner that emphasizes collaboration and the efficient and effective use of the resources expended by all parties directly participating in the

processes. IPRO validates each MCO's PIPs on an annual basis in compliance with CMS' most current Validating Performance Improvement Projects Protocol.

**Methodology**

*Preparation of Validation Methodology:* IPRO prepares the validation methodology including an MCO PIP submission form, reviewer tools, and reporting formats that are compliant with the CMS protocol. To help the MCOs plan their PIPs, at the beginning of each cycle IPRO provides submission requirements, timelines, and a submission form and instructions to standardize the submission process and facilitate comparisons among the MCOs.

*Training Webinar/Conference Call:* To assure the MCOs understand PIP validation activities, prior to PIP validation implementation IPRO conducts a training session. Topics for PIP training include:

- The PIP submission process
- Planning and implementing quality improvement strategies
- Measuring the effectiveness of interventions
- Conducting barrier analysis and developing interventions tailored to address these barriers
- Monitoring progress of interventions using process measures
- Sustaining and spreading measured improvement

*Assessing MCOs' Methodology for Conducting PIPs:* The MCOs are required to submit PIP methodology to IPRO for assessment. MCOs are required to document all PIP activities on the MCO PIP Submission Form and to submit this completed form annually to IPRO. Detailed submission instructions/requirements and a timeline regarding expectations related to IPRO's validation of the PIP are provided to all MCOs, including information that should be included in the various sections of the PIP Form for each year of submission. The Submission Form addresses PIP elements, including topic, rationale, indicators, objectives, methodology, data sources and collection procedures, and interventions (see Appendix A).

Each PIP is evaluated against the following elements:

**Demonstrable Improvement**

- Project Topic, Type, Focus Area (review of the study question for comprehensiveness and expected goal/outcome)
- Topic Relevance (review of the selected project topic for relevance of focus and for relevance to the MCO's enrollment and the Medicaid population)
- Quality Indicators (review of selected project indicators which should be objective, measurable, clear and unambiguous and meaningful to the focus of the PIP)
- Baseline Study Design/Analysis (review of data collection procedures to ensure complete and accurate data was collected)

- Baseline Study Population and Baseline Measurement/Performance (review of the identified study population to ensure it is representative of the MCO's enrollment and generalizable to the MCO's total population; review of sampling methods, if sampling is used, for validity and proper technique)
- Interventions aimed at Achieving Demonstrable Improvement (assessment of the improvement strategies for appropriateness and for overcoming barriers that have been identified)
- Demonstrable Improvement (assessment of likelihood that reported improvement is "real" improvement)

**Sustained Improvement**

- Subsequent or Modified Interventions (review of ongoing, additional or modified interventions)
- Sustained Improvement (assessment of whether the MCO achieved sustained improvement)

IPRO evaluates each element against questions adapted from the CMS protocol. The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last two relate to sustaining improvement from the baseline measurement.

**Reporting**

Once PIPs undergo an initial review, IPRO communicates a written assessment to each MCO for each PIP. This assessment is structured to document the evaluation according to the sections on the PIP form. The review may include questions that require MCO clarification and concerns regarding an MCO's potential achievement of compliance for the element(s) under review. IPRO coordinates conference calls with each MCO that receives the evaluation, as necessary, to discuss the review findings. After the written assessment is reviewed by the MCOs, they are given the opportunity to submit revised PIP documentation, when applicable.

In addition, for some PIPs, the MCOs are required to submit data analysis monthly to DHH. At the conclusion of each calendar year, the MCOs provide a written PIP report, as detailed in Appendix A. IPRO subsequently reviews each PIP and generates an evaluation report, which is detailed in Appendix B. This evaluation report is presented to DHH along with MCO-specific PIP validation findings and a report which summarizes annual PIP validation findings across the MCOs. A written interim, six-month report may also be required.

**Timeline**

| Task | Timeframe* |
|---|---|
| Plans submit PIP proposals to DHH; DHH sends PIP proposals to IPRO. | February of project year |
| IPRO teams review PIP Proposals, hold conference calls with the plans and prepare Summary Reports, including clarifications by the plans and IPRO recommendations. | February/March of project year |

| Task | Timeframe* |
|---|---|
| MCOs initiate their PIP projects. | March of the project year |
| IPRO holds calls with the plans to obtain progress reports from the plans and address the plans' issues and concerns. | Ongoing from March of project year |
| Plans send their interim PIP Final Reports to IPRO (as necessary). | September of project year |
| Plans submit annual Final Report to IPRO | April post project year |
| IPRO reviews the Final Reports, prepares Summary Reports and sends comments to the plans. | May post project year |
| Plans revise and send reports to IPRO, IPRO updates Summary Reports. | May post project year |
| IPRO sends all PIP Final Reports and Summary Reports to DHH. | June post project year |

*Approximate timeframes

# SECTION 5: PERFORMANCE MEASURES (PMs)

## Process Overview

The Louisiana (LA) Department of Health and Hospitals (DHH) selected MCO quality performance measures to assess access to care, effectiveness of care and use of services.

The first performance measurement period for all MCOs is expected to be calendar year 2015. This approach affords a full year of service data for the collection and calculation of PMs.

One of the mandatory activities for External Quality Review (EQR) is validation of performance measures to assess the accuracy and reliability of the PMs reported by the MCOs and to determine the extent to which they follow established measure technical specifications and are in accordance with the specifications in 42 CFR §438.354(c).

The CMS protocols specify that in lieu of conducting a full onsite Information Systems (IS) assessment, the EQRO may review an assessment of the MCO's information systems conducted by another party. If an MCO is NCQA-accredited, the MCO will have received a full IS assessment as part of its annual HEDIS® audit by an NCQA-licensed audit organization. In this case, IPRO requests and reviews the MCO's Roadmap, Final Audit Report and Data Submission Tool in lieu of conducting an onsite assessment.

## Task Description

The *Validation of PMs* task assesses the MCOs' process for calculating performance measures and whether the process adhered to each measure's specifications, and the accuracy of the performance measure rates as calculated and reported by the MCOs. Each assessment includes a documentation review (desk audit), MCO staff interviews and, as appropriate, direct observation of key program areas. The assessment is completed in three phases:

Phase One – Pre-onsite activities (planning and preparation)
Phase Two – Onsite activities (validation review)
Phase Three – Post-onsite activities (post-review follow up and report preparation)

The validation follows a structure similar to HEDIS compliance audits but focuses on systems assessment and is fully compliant with the CMS EQRO protocol for Validating Performance Measures.

Note that for the state-specific performance measures an onsite visit is, in all likelihood, not necessary. IPRO may need to only evaluate source code and/or conduct medical record review to validate the MCO's calculation of the measures. An onsite visit is usually only required when the MCO hasn't undergone an NCQA-required HEDIS audit. The following methodology will be conducted only in those special circumstances when a formal validation that includes an onsite visit is required.

## Methodology

Phase One: Pre-Onsite Validation Activities

*Preparation of Validation Methodology*: IPRO prepares the validation methodology including validation tools, and reporting formats that are compliant with the CMS protocol.

*Preparation of Validation Tools:* An automated Microsoft Access-based Information Systems (IS) Standards Tool is used to guide IPRO reviewers in thoroughly documenting critical findings while ensuring consistency among validation team members.

IPRO uses a HIPAA-compliant, hierarchical electronic file storage system for organizing and maintaining validation-related working papers. To ensure member confidentiality, any Protected Health Information (PHI) shared between reviewers and the MCO is transmitted via HIPAA-compliant FTP sites.

*Training Webinar/Conference Call:* IPRO provides training prior to PM validation to explain the validation process and timeline, and respond to questions.

*Scheduling the Onsite Visit*: IPRO contacts each MCO to arrange a mutually agreeable date for the onsite visit and schedule a pre-onsite conference call to assure their readiness for the onsite assessment. Within two weeks prior to the scheduled visit, a confirmation letter and onsite agenda is sent to the MCOs.

*Introductory Letter*: IPRO prepares the MCOs for PM validation via an introductory letter that outlines the procedures and timelines for conducting validation activities and explains the purpose of the onsite visit and interview process. The letter asks each MCO to identify its point of contact for the validation and to provide any information requested to the IPRO Validation Team prior to the onsite visit. The letter also provides IPRO Validation Team contact information for technical assistance and alerts the MCO to expect electronic delivery of the Introductory Package.

*Introductory Package*: The Package provides preparatory information such as a list of the required PMs with a request for numerators, denominators, and rates calculated by or on behalf of the MCO, a list of enrollees included as PM numerator positives by medical record review, a list of documents to be reviewed, and IS background information including the Information Systems Capabilities Assessment Tool (ISCA) to complete and return prior to the site visit.

*Review of Pre-onsite Documentation*: Prior to the onsite visit, the MCOs complete and return the ISCA to the IPRO Validation Team. The ISCA helps the MCO to explain the process it used to calculate each numerator, denominator, and subsequent PM rates. IPRO uses the ISCA as the basis for our initial assessment of the MCO's compliance with the PM specifications. It is reviewed for information about the MCO's systems for collecting and processing data to produce PMs, plan the onsite activities, and identify areas that require clarification during the onsite visit. During the onsite visit, the Validation Team conducts primary source verification of the MCO's responses to the ISCA questions.

Phase Two: Onsite Validation Activities

*Opening Conference*: The onsite validation begins with an opening conference, at which IPRO reviewers and MCO staff are introduced. During the opening, IPRO provides an overview of the purpose of and process for the review and onsite agenda.

*Onsite Review*: During the onsite visit, the IPRO Validation Team interviews and reviews documentation with appropriate MCO staff and observes workflow and practices related to the MCO Information Systems that collect, process and transmit PM data. If the MCO delegates any aspect of data collection or reporting to an external vendor, the same assessment is applied to the vendor's documentation of programs or processes used in generating, collecting, and/or analyzing the data in question. For each MCO, IPRO conducts several onsite activities, including:

- *Interviewing*: IPRO verifies the responses in the ISCA Tool and obtains more detailed information by interviewing staff who are responsible for the MCO's Information Systems and involved in the PM data collection process. Interviews are tailored to the MCO's PM production environment.

- *Primary Source Verification:* IPRO reviews applicable paper forms and other input media used to produce the PMs (e.g., claims and encounters, practitioner information and Electronic Data Interchange (EDI) protocols, and verifies that the information from the primary source matches the information reported. We also review the processes used by the MCO to input, transmit and track the data, confirm entry and detect errors.

- *Review of Information Systems Processes and Documentation:* IPRO reviews documents that describe the MCO's processes relative to the collection, storage and reporting of data, focusing on the integrity and completeness of the data required for PM reporting. We may also observe certain procedures and review instructions and other related documentation, such as the capture of member-level information regarding additions, deletions and changes in enrollment, or the design of databases to ensure that they are compliant for the PMs.

- *Systems or Program Review:* IPRO reviews the MCO's systems and programs governing the entry, transfer, editing and manipulation of the data, such as file formats and data receipt, entry and transfer processes.

- *Observation/Systems Walkthrough:* To ensure that the MCO's formal policies and procedures are properly followed, the IPRO Validation Team conducts a walkthrough to directly observe entry of claims and encounters, as well as the MCO's enrollment system, provider data warehouse and performance measure repository files and programs.

- *Assessment of Data Completeness*: IPRO assesses over- and under-reporting of data. Over-reporting errors are identified as double-counting of services. IPRO assesses the MCO's claim lag and provider encounter data submission results, and evaluates any studies on data completeness that the MCO may have performed. IPRO also assesses the impact of capitation and other contractual agreement methods on data completeness, as applicable. If data completeness issues are significant and substantiated, we inform the

MCO of measures that may potentially be at risk, and work with MCO staff to identify short- and long-term measures to minimize potential reporting bias.

*Source Code Review (Onsite or Offsite):* IPRO reviews source code to assess compliance with PM technical specifications. The MCOs are required to submit to IPRO the source code used to generate eligible populations, denominator requirements and numerator compliant hits for each PM along with related flowcharts, software documentation, input and output file record layouts and field descriptions, input and output record counts and job logs. IPRO reviews the source code to assess compliance with technical specifications for all calculations (eligible population, denominator, numerator and algorithms) for each PM. Concurrently, IPRO validates the accompanying member level data files by conducting several checks on each file.

*Closing Conference:* At the conclusion of the onsite visit, IPRO conducts an exit conference to present preliminary findings, identify measures at risk, review follow-up items, discuss any required corrective actions and review the timeline for completing post-onsite activities and final reporting.

*Medical Record Review (MRR) Validation and Process Evaluation:* A sample of measures will be selected for validation. For each of the measures calculated via medical record review, IPRO validates medical record data by reviewing the MCOs' medical record data collection tools and abstraction processes, and by conducting a physical review of a sample of records from each MCO. Nurse reviewers conduct the MRR validation process.

IPRO requests numerator listings from each MCO for those cases that were identified as numerator positive from the MCO MRR. IPRO randomly selects thirty medical records for review and requests copies of these records. IPRO's nurse reviewers review the medical records and the MCO-completed abstraction tools to determine if they were in agreement with the MCO determinations. IPRO staff notifies the MCOs of the nurse reviewers' findings and provides the MCOs the opportunity to provide additional documentation, as available. If after this the agreement rate is less than 100%, IPRO conducts final statistical validation utilizing the t-test developed by NCQA to confirm that the results do not significantly bias the hybrid rate.

If the MCO delegates any aspect of data collection or reporting to an external vendor, the same assessment is applied to the vendor's documentation of programs or processes used in generating, collecting or analyzing the data in question.

Phase Three: Post-Onsite Validation Activities

The final phase of performance measure reporting entails IPRO's preparation of rate tables and analysis reports of PM results. IPRO generates PM rate tables using validated data submitted by the MCOs. Rate tables may include "drill down" calculations based on various subpopulations, such as by race, ethnicity, age, gender, parish, etc.

IPRO also applies analytical and presentation tools to transform results into quantitative information that informs DHH and the MCOs of performance and opportunities for improvement. Whenever possible, comparative and analytical results are presented in a graphic format.

Statistical comparison against prior years' performance measure rates and year-to-year trending are presented, as applicable. At a minimum, MCO HEDIS rates are evaluated against HEDIS benchmarks, i.e., HEDIS Audit Means, Percentiles and Ratios included in NCQA's Quality Compass.

The MCO-specific validation reports are submitted to DHH and the MCOs at DHH's discretion.

**Timeline (HEDIS 2015)**

| Task | Timeframe |
|---|---|
| MCOs report HEDIS/PMs to NCQA via the IDSS or other reporting mechanism (for the state-specific measures) | June 15 |
| MCOs submit the IDSS workbook, Audit Designation Table and Roadmap to DHH via the IPRO FTP site | June 16 |
| MCOs submit final audit reports to DHH via the IPRO FTP site | July 31 |
| IPRO, in conjunction with DHH, compiles the MCOs' rates, including statewide averages | August 31 |

## MCO Performance Measures

MCOs are required to submit performance measures to DHH as described in Appendix C.

Incentive-based measures may affect MCO payments. These can be found in Appendix C, annotated with "$$" (there are eight incentive-based measures in total).

# SECTION 6: TECHNICAL REPORT

## MCO Technical Report Content

The final rule of the Balanced Budget Act (BBA) of 1997 requires that State agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid Managed Care recipients.

The EQR-related activities that must be included in detailed technical reports are:

- review to determine MCO compliance with structure and operations standards established by the State (42 CFR §438.358),
- validation of performance improvement projects, and
- validation of MCO performance measures.

For each contract year, IPRO produces Technical Reports that assess the MCOs' performance, in compliance with the requirements of 42 CFR §438.364 and Louisiana State specifications. IPRO prepares a report for each MCO and one statewide aggregate report which includes all MCOs. IPRO submits the MCO-specific reports to DHH within thirty (30) days after completion of the annual review of each MCO.

IPRO works with DHH to identify the domains and data to be included in the MCO-specific Technical Reports and in the statewide aggregate Technical Report and establish a production timeline.

The following information is included in the annual MCO Technical Reports as appropriate to the report type:

- Objectives;
- A brief review methodology description of the technical methods of data collection and analysis, a review process overview, the scoring criteria, and the steps taken to prepare the reviewers and validate reviewer-completed instruments;
- Follow-up activities since the preceding review;
- Description of the data obtained and the collection and analysis process;
- MCO-specific findings, including best practices;
- Findings by each category of requirements;
- Conclusions drawn from the data;
- Trends in evaluation findings over the years that reviews have been completed;
- Opportunities for improvement and recommendations;
- An assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness and access to health care services furnished to Medicaid recipients;

- Methodologically appropriate, comparative information about all MCOs operating within Louisiana, as determined by DHH; and
- An assessment of the degree to which an MCO has effectively addressed the recommendations for quality improvement made by IPRO during the previous year's EQR.

The Technical Reports are prepared in both electronic and hard copy formats in accordance with all contract and DHH specifications.

**MCO Technical Reports**

As applicable, the MCO-specific Technical Reports provide the objectives for each key activity, the methods used to measure these objectives, and key findings and conclusions resulting from the data. The reports combine text, tables and graphs to best display each data set in a way that is easily understandable. If appropriate, IPRO conducts significance testing for each figure to provide a functional way to compare each MCO to statewide and/or national benchmarks, and includes multiple years for trending purposes.

The MCO-specific Technical Reports provide an assessment of the strengths and opportunities for improvement for each MCO relative to timeliness, access and quality of services delivered to members, and IPRO's recommendations. MCO-specific Technical Reports produced after the first year include an assessment of the degree to which each MCO has effectively addressed the performance improvement recommendations made by IPRO during the previous year's external quality review.

Timeline

| Task | Timeframe* |
|---|---|
| IPRO collects data from DHH/MCOs for inclusion in the Technical Report | October to January of each contract year |
| Submit draft of Technical Report to DHH for review | Late February of each contract year (effective 2016) |
| Prepare and submit final report to DHH based upon DHH feedback | Late March of each contract year (effective 2016) |
| MCOs respond to IPRO recommendations | December of each contract year |

*Approximate timeframes

# SECTION 7: MEDICAL LOSS RATIO (MLR) RECOMMENDATIONS

## Process Overview

IPRO will review each MCO's MLR rebate calculation document to compare and ascertain alignment with the Code of Federal Regulations for MLR. Specifically, IPRO will review MCOs' MLR policy and calculation documents to ensure that the following regulated components are addressed:

*2.3.4.1 Disclosure and Reporting: Sub Part A*

- Reporting requirements related to capitation payments and expenditures: 45 CFR158.110
- Aggregate Reporting: 45 CFR 158.120
- Newer experience: 45 CFR 158.121
- Premium Revenue: 45 CFR 158.130
- Reimbursement for clinical services provided to enrollees: 45 CFR 158.140
- Activities that improve healthcare quality: 45 CFR 158.150
- Expenditures related to Health Information Technology and meaningful use requirements: 45 CFR 158.151
- Other non-claim costs: 45 CFR 158.160
- Reporting of federal and state licensing and regulatory fees: 45 CFR 158.161
- Reporting of federal and state taxes: 45 CFR 158.162
- Allocation of expenses: 45 CFR 158.170

*2.3.4.2 Calculating and Providing the Rebate: Sub Part B*

IPRO will review the MCO's formula for calculating MLR to ensure that the formula complies with that stipulated in 45 CFR 158.221 and that the plan's policies for rebating payments (if the 85% MLR standard is not met) complies with CFR 158.240. On an annual basis, IPRO will also conduct an MLR quality review of the reported MLR. Specifically, the activities and expenses reported in 45 CFR 158.150 and 45 CFR 158.151 will be reviewed to determine if they are quality related.

Activities conducted to improve quality must be primarily designed to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline, and reduce health disparities among specified populations;
- Prevent hospital re-admissions through a comprehensive hospital discharge program;
- Improve patient safety, reduce medical errors and lower infection and mortality rates;
- Implement, promote and increase wellness and healthy activities; or
- Enhance the use of healthcare data to improve quality, transparency and outcomes, and support meaningful use of health information technology.

Primary quality activities are those associated with care management, disease management and wellness programs. These activities will comprise the focus of IPRO's review. Primary activity examples include:

- Arranging and managing care (e.g., primary care, specialty care, care transitions);
- Medication and care compliance;
- Programs to support shared decision making with patients, families, representatives;
- Use of medical homes;
- Comprehensive discharge planning;
- Prospective medical and drug utilization review;
- Wellness and health promotion activities (e.g., coaching and incentive programs for smoking, obesity); and
- Certain health information technology expenses (those associated with quality related activities or activities that assist providers in the adoption and meaningful use of certified electronic health record technology and fees/subscriptions paid to the Louisiana Health Information Exchange or LaHIE).

**Timeline**

| Task | Timeframe* |
|---|---|
| IPRO conducts a review of each MCO's policy and calculation documents, and review of each MCO's MLR calculation. | September-December of each project year |
| IPRO prepares a summary report of MLR findings for the DHH | By January 31 of each project year, beginning with the year following the first project year (January 31, 2016) |

*Approximate timeframes

# SECTION 8: FOCUSED STUDIES

## Process Overview

Focused studies assist DHH in evaluating the safety, quality, timeliness and efficiency of care provided to MCO enrollees, and ensure that care is patient-centered and equitable. Studies are designed and conducted in collaboration with DHH and in accordance with CMS' most current EQR protocol for conducting focused studies of healthcare quality.

## Task Description

IPRO will work with DHH to identify topics that are aligned with the state's priorities and goals. In proposing topics, IPRO will consider clinical conditions and health service delivery issues that have the highest prevalence or incidence among Louisiana MCO members, the greatest potential for improving health outcomes and the overall potential impact on the Medicaid program.

For Louisiana, IPRO recommends conducting one focused study using administrative data supplied by the state or MCOs, and the second study using data abstracted from medical record review.

Recent focused studies IPRO conducted include medical record review studies to evaluate:

- Prenatal and postpartum care;
- Care for members with Attention Deficit Hyperactivity Disorder (ADHD);
- Depression screening in primary care;
- Care for members with asthma;
- Discharge practices and risk factors for maternal postpartum hospital readmission and newborn hospital readmission;
- Diagnostic and Treatment Services (EPSDT);
- Preventive services for Children with Special Healthcare Needs (CSHCN); and
- Early childhood developmental surveillance and screening.

IPRO recently conducted focused studies using administrative data to evaluate:

- Utilization patterns of Medicaid managed care members with co-occurring physical health and behavioral health conditions, diagnoses and other characteristics associated with emergency department (ED) utilization;
- Diagnoses and characteristics associated with prenatal and postpartum hospital and ED utilization; and

- Co-morbid conditions, behavioral risk factors and demographic factors associated with appropriate asthma medication.
- IPRO has evaluated MCO care management practices based on enrollment and medical record data using predictive modeling software.
- IPRO has also conducted survey studies to evaluate MCO members' experience of care, such as postpartum members, members enrolled in Medicaid Managed Long Term Care, Children with Special Healthcare Needs (CSHCN), and members receiving Supplemental Security Income (SSI) who were recently transitioned to Medicaid managed care.

**Methodology**

As per the CMS protocol, focused studies will be conducted following the steps below:

1) Select the study topic
   In proposing topics, IPRO will consider clinical conditions and health service delivery issues that have the highest prevalence or incidence among Louisiana MCO members, the greatest potential for improving health outcomes and the overall potential impact on the Medicaid program. Examples of types of studies that could be considered include:
   - Primary and preventative services
   - Chronic/acute conditions
   - Ambulatory care sensitive conditions
   - Continuity and care coordination, including care transitions
   - Co-occurring behavioral health and physical conditions
   - Health service delivery issues
   - Access/utilization studies
   - Inappropriate treatments/management
   - Disparities including differences among demographic subsets
   - Outcome studies
2) Define the study questions
3) Select the study variable(s)
4) Study the whole population or use a representative sample
5) Use sound sampling methods
6) Reliably collect data
7) Analyze data and interpret study results
8) Report results to DHH

Once the study topic has been identified, IPRO submits a proposed study design to DHH that includes study topic, aim, study questions, indicators, eligible population and sampling strategy, data collection methodology and analysis methodology. Once the proposal is finalized, IPRO will develop and submit a detailed data analysis plan that will outline schemes for data analysis and reporting, including organization of indicators into domains, composite variables as applicable, groups for comparative analyses, other applicable analyses and statistical tests, and

sample tables for presentation of data. Final study reports submitted to DHH include an executive summary, introduction, objectives, methods of data collection and analysis, results, discussion, limitations, conclusions and recommendations for improvement and issues requiring further study.

The start date of focused studies and the timeline will be determined following discussion with the DHH.

# SECTION 9: PROVIDER SURVEYS

## Process Overview

Louisiana requires the EQRO to design and implement one statewide provider survey per year. Through provider surveys, DHH can evaluate the experience of specific types of providers in the Medicaid managed care program, the effectiveness of certain managed care or Medicaid programs, and/or how satisfied Medicaid providers are with a particular aspect of an MCO's performance.

### Task Description

IPRO designs and conducts provider access and availability surveys and provider network audits that target primary care providers, specialists, behavioral health providers, and ancillary, non-ancillary and institutional providers.

Provider survey components for consideration may include:

- MCO's support of the providers in enhancing quality of care for their patients;
- Impact of the MCO on areas such as physician independence, the physician-patient relationship, quality of care, availability of preventive care and access to care;
- Satisfaction and quality of communication with other providers in the MCO network;
- Contracting process between the provider and the plan; and
- Quality/amount of technical assistance provided by the plan to support enhanced quality of care.

An appropriate survey topic meets some or all of the following criteria:

- The issue is of strategic importance to the Medicaid managed care program;
- The issue is of importance to Louisiana, MCOs, and providers;
- The issue relates to the management of the Medicaid managed care program;
- The issue pertains to a timely quality of care concern;
- The issue will be helpful in differentiating MCOs and in assessing MCO performance;
- The issue relates to uncovering barriers in the provision of services and in the efficiency of the services delivered.

### Methodology

In deciding on survey topics, IPRO provides guidance on research findings pertaining to issues of importance to the Medicaid provider population and information on topics being studied in other states. Topic selection will be followed by the technical process of survey development. In collaboration with DHH, IPRO will develop the survey, ensuring that the questions reflect the state's objectives and that the survey itself is as streamlined as possible to maximize response rates. At the outset of the project, IPRO will submit a survey data analysis plan/template to DHH for review so modifications can be made. At the conclusion of the project, IPRO reports results and actionable findings.

The start date of provider surveys will be determined following discussion with the DHH. An approximate timeline is presented below.

**Timeline**

| Task | Timeframe* |
|---|---|
| IPRO meets with Louisiana to discuss survey methodology, survey instrument, and mailing materials | Month one |
| IPRO develops study specifications and protocols, e.g. draft survey methodology, sampling, survey administration, instrument and materials | Month Two |
| IPRO obtains and checks provider file | Month Three |
| IPRO selects study sample and conducts field preparation including formatting, assembling, and printing mailing materials | Month Three |
| IPRO sends first mailing of questionnaires to providers | Month Four |
| IPRO sends second mailing of questionnaires to non-responders | Month Five |
| IPRO prepares and distributes data analysis plan to DHH | Month Five |
| IPRO conducts data analysis | Month Six |
| IPRO prepares and submits final report to DHH | Month Seven |

*Approximate timeframes

# Appendix A

# MCO Performance Improvement Project (PIP)

## Insert Health Plan Name Here

## Insert Report Title Here

Insert either:

## Project Proposal
## Interim Report or
## Final Report

**Submission to:**
LA Department of Health and Hospitals
IPRO

# Health Plan and Project Identifiers

Please complete all fields as accurately and as completely as possible.

**1. Name of Health Plan:**

**2. Select the Report Submission:** [If any change from initial submission, please complete section 7 below.]

☐ PIP Part I: Project Proposal Date submitted: ____/____/____
☐ PIP Part II: Interim Report Date submitted: ____/____/____
☐ PIP Part III: Final Report Date submitted: ____/____/____

**3. Contract Year:**

**4. Principal Contact Person:**
[person responsible for completing this report]

**4a. Title:**

**4b. Phone:** (___)_____-_____ ext.

**4c. Email Address:**

**5. Title of Project:**

**6. External Collaborators (if any):**

**7. For Interim and Final Reports Only: If Applicable, Report All Changes from Initial Proposal Submission:** [Examples include: added a new survey, added new interventions, changed interventions, deviated from HEDIS® specifications, reduced sample sizes]

## 8. Attestation

The undersigned approve this PIP Project Proposal and assure their involvement in the PIP throughout the course of the project.

_____

Health Plan Name

_____

Title of Project

_____

Medical Director (print, sign and date)

_____

Quality Director (print, sign and date)

_____

IS Director (when applicable) (print, sign and date)

_____

CEO (print, sign and date)

# Project Topic

Provide a general description of the project topic that is clearly stated and relevant to the enrolled population.

## 1. Describe Project Topic

[Project topics should be based on the needs of the plan's member population (i.e., should reflect member needs, care and services and reflect high-volume or high-risk conditions/events) and should be supported by current research, clinical guidelines or standards. The Health Plan should provide a clear and detailed description of the selection and prioritization process used in topic selection.]

## 2. Rationale for Topic Selection

[Explain why this activity is important to members or practitioners, *and* why there is an opportunity for improvement. Describe how the project or results will help practitioners, members, or plan processes. The rationale for the topic selected should be reasonable given Health Plan demographics, be based on objective supporting data (e.g., HEDIS®, Health Plan baseline data, member/provider surveys), and pertain to a sufficient number of members to yield interpretable findings. Support rationale with documentation from the literature, using citations].

## 3. Aim Statement

[State the question(s) that the project is designed to answer. Address what the project is trying to accomplish, including WHO (patient population), WHAT (the intent of the project), WHERE (pilot site and spread sites), and WHEN (timeline). Align the aim with the strategic goal of the organization. The project objectives should be clear and set the framework for data collection, analysis, and interpretation. Anticipated barriers and how they will be addressed may be considered. Examples of objectives include improving HEDIS rates, member satisfaction, access to care, and adherence to clinical guidelines. Specify a target or goal for improvement that is practical, achievable, unambiguous, and quantifiable. Benchmark data can be used for comparative purposes (e.g., HEDIS® rates, Healthy People 2010, published articles).]

# Methodology

The methodology section describes how the data for the project are obtained.

## 1. Performance Indicators

[Indicators should be measurable, objective, clearly defined, and flow directly from the study aim. If using HEDIS®, specify reporting year used. If not using HEDIS®, or using a modified HEDIS® measure, clearly state how your indicators will be measured, including a description of the indicator numerator and denominator. Health Plan developed indicators should be evidence-based and refer to recognized clinical guidelines or expert consensus. Define the criteria used for selecting the eligible population, and describe any exclusion criteria. State whether the methodology for the remeasurement differs in any way from that used for the baseline assessment, include type of change, rationale for change, and any bias that could affect the results. When employing a quality improvement model, it is preferable to report an intermediate measure to evaluate performance and the further need for change. Process measures are the workings of the system (the parts/steps in the system) whereas outcome measures are the result (how the system is performing). Examples are the percentage of patients with an LDL test in the past year, (process) and percentage of patients with LDL <100 (outcome).]

## 2. Procedures

[Describe the method of data collection, including who collects the data and the instruments used, as well as efforts to ensure validity and reliability. Clearly identify the sources of data, and specify if using administrative data, medical record data, hybrid methodology, and/or surveys. Describe any data collection tools that are employed. Report whether sampling is used. If so, describe the sampling method, and if stratification was used. Report the sample size and verify that it includes all relevant subsets of the population. Describe measures taken to ensure that members with special health care needs are not excluded. If a survey is used, detail the mode of survey (e.g., mail, phone), the number of cases to receive a survey, and follow-up attempts to increase response rates, if any (e.g., re-mailing of surveys). If using statistical testing, specify the procedures used for analysis.]

## 3. Project Timeline

[The timeline should include all important dates regarding the conduct of the study, including baseline measurement period, interventions, remeasurement period, analysis, final report. Complete the table below. For each event, provide a date or date range (start and end dates), as applicable.]

| Event | Timeframe |
|---|---|
| Baseline Measurement Period | |
| Interim Measurement Period | |
| Submission of Interim Report (if applicable) | |
| Re-measurement Period | |
| Intervention Implementation | |
| Analysis of Project Data | |
| Submission of Final Report | |

# Interventions/Changes for Improvement

Interventions should be targeted to the study aim and should be reasonable and practical to implement considering plan population and resources.

## 1. Interventions Planned and Implemented

[Describe each intervention and the decision-making process leading to the selection of the intervention. Detail how the intervention is reasonably able to impact the enrolled population/improve health outcomes, and likely to induce a permanent change rather than a short-term or one-time effect. Interventions should be based on evidence of effectiveness. If the intervention is based on literature, include appropriate citations. Specify identified barriers to care that interventions are designed to impact. Describe whose performance the intervention is intended to affect (e.g., members, Health Plan clinical staff, providers, community). Provide the start and end dates of each discrete intervention. The interventions should be timed for optimal impact, ideally after baseline, allowing enough time to impact remeasurement. Given the time parameters of the project, an interval of at least 6 to 9 months is generally necessary to detect measurable impact of your interventions.]

Complete the sections in the table below, and add more rows as needed. For each intervention, provide date ranges (start and end dates) in the first column of the table. Interventions that began post-remeasurement should not be listed as interventions since they could not impact the rates. They should be highlighted in the Next Steps section.

| Intervention Timeframe | Description of intervention |
|---|---|
| | |
| | |
| | |

## 2. Barrier Analyses

[Barrier analysis should be conducted as part of the project design. Describe the barriers that your interventions are designed to overcome, e.g., lack of member or provider knowledge, lack of transportation, lack of standardized tools, lack of adequate discharge planning. Barrier analyses should include analyses of data, both quantitative and qualitative (such as focus groups or interviews) and published literature where appropriate. Barriers are distinguished from challenges you confronted in conducting the study. Those challenges should be described in the Limitations section.]

# Results

The results section should quantify project findings related to each study question and project indicators. **Do not** interpret the results in this section.

[Explain how the data were analyzed to address the objectives. Important results to include:

- Entire population size and number of cases in the project sample
- Number of cases excluded due to failure to meet criteria
- Rates for project indicators—numerator and denominator for baseline and remeasurement
- Performance targets
- Statistical tests and results (if applicable)
- Run/Control Charts
- How missing data and outliers were handled

Tables/graphs/bar charts are an effective means of displaying data in a concise way to the reader. Appendix A contains examples of tables as well as instructions on creating useful tables.

Tables should be accompanied by text that points out the most important results, simplifies the results, and highlights significant trends or relationships. Tables should be able to stand alone.

If a survey was conducted, list the final sample size, the number of responses received, and the response rate. Reasons for low response rates or failure to obtain eligible records should be described.]

# Discussion

The discussion section is for explanation and interpretation of the results.

## 1. Discussion of Results

[Explain and interpret the results by reviewing the degree to which objectives and goals were achieved, the meaningfulness of improvements or changes, and what factors were associated with success or failure. Describe whether results were expected or unexpected, and provide other possible explanations for the results. Comment on “face validity,” i.e., does the improvement in performance appear to be the result of the quality improvement interventions. A brief conclusion should be provided based on the reported results. The basis for all conclusions should be explained.]

## 2. Limitations

[Address the limitations of your project design. Identify methodological factors that may jeopardize the internal or external validity of the findings. Describe any challenges or barriers identified in implementing the interventions and how they were addressed (e.g., difficulty locating Medicaid members, lack of resources, reasons for low survey response rates, insufficient number of providers in rural areas. Indicate if an intervention was planned but was not implemented or if the intervention was changed in any way, and why.]

# Next Steps

In this final section, discuss ideas for taking your project experience and findings to the next step.

## 1. Lessons Learned

[Describe what was learned from the project, what remains to be learned, what can be changed as a result of the project, and whether findings can be extrapolated to other members or systems.]

## 2. System-level Changes Made and/or Planned

[Describe how findings will be used, actions that will be taken to sustain improvement, and plans to spread successful interventions to other applicable processes in your organization.]

# Appendix A: Examples of Tables

Tables can include 95% confidence intervals corresponding to each of the proportions, goals and benchmarks (such as the statewide average), or other descriptive statistics such as average, median, range, and outliers, if appropriate.

You do not have to choose one of these tables: they are for reference purposes only. Create a table that is appropriate for your unique data, but follow the general guidelines:

- Table titles should always be understandable and stand-alone.
- Table column headings should include the number of members in each group.
- Each column should have a heading.
- Report statistical significance using asterisks or significance level in a column.

**Sample Table 1: Rate of [*Project Indicator*], Year 1-3**

| Year | Numerator | Denominator | % | 95% CI |
|---|---|---|---|---|
| Year 1 | | | | |
| Year 2 | | | | |
| Year 3 | | | | |

**Sample Table 2: Baseline and Remeasurement Rates for Each Project Indicator**

| Indicator | Baseline | | Remeasurement | | P value |
|---|---|---|---|---|---|
| | n | % | n | % | |
| Indicator 1 | • | • | • | • | • |
| Indicator 2 | • | • | • | • | • |
| Indicator 3 | • | • | • | • | • |

**Sample Table 3: Baseline and Remeasurement Rates for Plan and Statewide Average**

| Indicator | Plan | | SWA | | P value |
|---|---|---|---|---|---|
| | n | % | n | % | |
| Baseline Year | • | • | • | • | • |
| Remeasurement Year | • | • | • | • | • |
| Difference | • | • | • | • | • |

**Sample Table 4: Record Retrieval Information by Provider**

| | Records from Provider 1 | Records from Provider 2 | Total |
|---|---|---|---|
| Records Requested | | | |
| Records Received | | | |
| Records Not Received (but included in analysis) | | | |
| Records Excluded | | | |
| Total Usable Cases | | | |

# Appendix B

# [YEAR]LA MCO Performance Improvement Project
# Summary Evaluation Report

**Plan Name:**
**Study Topic:**
**PIP Period:**

**IPRO Reviewers**
Name: Tel: email:
Name:

**MCO Contact**
Name:
Tel:
Email:

**Project Objective(s)**

**Interventions Summary**

**Results Summary**

**Detailed Listing of Strengths and Opportunities for Improvement**

**Strengths**

- XXXXXXXXXXXXXXX

**Opportunities (Areas for Improvement)**

- XXXXXXXXXXXXXXXXX

**Summary of Strengths and Opportunities**

**Overall Credibility of Results**

# Appendix C

## Bayou Choices Performance Measures

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
|---|---|---|---|---|
| Initiation of Injectable Progesterone for Preterm Birth Prevention (PTB)* ($$) | The percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more progesterone injections between the 16th and 21st week of gestation.* | DHH/ULM | Women aged 15-45 with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation)* | Women who had at least one progesterone injection between the 16th and 21st week of pregnancy. * |
| Cesarean Rate for Low-Risk First Birth Women ($$) | The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions). | TJC | Nulliparous members ICD-9 procedure code for outcome of delivery (as defined in the appendices of the original measure documentation) and with a delivery of a newborn with 37 weeks or more of gestation completed. | Patients with ICD-9-CM procedure code for cesarean section (as defined in the appendices of the original measure documentation). |
| Behavioral Health Risk Assessment (for Pregnant Women) | The percentage of women, regardless of age, that gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression, alcohol use, tobacco use, drug use, and intimate partner violence. | AMA-PCPI | All members, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care. | Members who received the following behavioral health screening risk assessments at the first prenatal visit:<br>**Depression screening:** Members who were screened for depression at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool (e.g., Patient Health Questionnaire-2 [PHQ-2], Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale [EPDS]).<br>**Alcohol use screening:** Members who were screened for any alcohol use at the first visit |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Behavioral Health Risk Assessment (for Pregnant Women) (continued from previous page) | | | | **Tobacco use screening:** Members who were screened for tobacco use at the first visit<br>**Drug use (illicit and prescription, over the counter) screening:** Members who were screened for any drug use at the first visit<br>Intimate partner violence screening: Members who were screened for intimate partner violence/abuse at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Intimate partner violence screening may include a self-reported validated depression screening tool (e.g., Hurt, Insult, Threaten, and Scream [HITS], Woman Abuse Screening Tool [WAST], Partner Violence Screen [PVS], Abuse Assessment Screen [AAS]). To satisfactorily meet the numerator – ALL screening components must be performed. |
| Frequency of Ongoing Prenatal Care | The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following percentages of expected prenatal visits: <21, 21-40, 41-60, 61-80, > or ≥81. | NCQA | Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in a birthing center. | Women who had an unduplicated count of <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age. For each delivery, follow the steps below to calculate each woman's ratio of observed-to-expected prenatal care visits. |
| Percentage of Low Birth Weight Births | The percentage of live births that weighed less than 2,500 grams in the state during the reporting period. | CDC | Total births for all women who were seen for prenatal care during the measurement regardless of who did the delivery | Women from the denominator whose child weighed less than 2,500 grams during the measurement year, regardless of who did the delivery |
| Timeliness of Prenatal Care (PPC Submeasure) | The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. | NCQA | Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in a birthing center. | A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy. Include only visits that occur while the member was enrolled. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Postpartum Care (PPC Submeasure) ($$) | The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. | NCQA | Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in a birthing center. | A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Any of the following meet criteria:<br>• A postpartum visit.<br>• Cervical cytology.<br>• A bundled service where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered). |
| Adolescent Well Care Visit ($$) | The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year | NCQA | Members 12–21 years as of December 31 of the measurement year. | At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the member. |
| Child and Adolescents' Access to Primary Care Practitioners | The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.<br>• Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.<br>• Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year. | NCQA | Members 12 months–19 years as of December 31 of the measurement year. Report four age stratifications:<br>• 12–24 months. Include all children who are at least 12 months old but younger than 25 months old during the measurement year (i.e., born on or between December 1, 2012 and December 31, 2013).<br>• 25 months–6 years. Include all children who are at least 2 years and 31 days old but not older than 6 years during the measurement year (i.e., born on or between January 1, 2008 and November 30, 2012).<br>• 7–11 years.<br>• 12–19 years. | **For 12–24 months, 25 months–6 years:** One or more visits with a PCP during the measurement year.<br>**For 7–11 years, 12–19 years:** One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year or the year prior to the measurement year.<br>Count all members who had an ambulatory or preventive care visit to any PCP. Exclude specialist visits. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Childhood Immunization Status | The percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday. | NCQA | Children who turn 2 years of age during the measurement year. | **DTaP.** At least four DTaP vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.<br>**IPV.** At least three IPV vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.<br>**MMR.** Any of the following with a date of service on or before the child's second birthday meet criteria:<br>• At least one MMR vaccination.<br>• At least one measles and rubella vaccination and at least one mumps vaccination on the same date of service or on different dates of service.<br>• At least one measles vaccination and at least one mumps vaccination and at least one rubella vaccination on the same date of service or on different dates of service.<br>• History of measles, mumps or rubella illness.<br>**HiB.** At least three HiB vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.<br>**Hepatitis B.** Either of the following on or before the child's second birthday meet criteria:<br>• At least three hepatitis B vaccinations, with different dates of service.<br>• History of hepatitis illness.<br>**VZV.** Either of the following on or before the child's second birthday meet criteria:<br>• At least one VZV vaccination, with a date of service on or before the child's second birthday.<br>• History of varicella zoster (e.g., chicken pox) illness.<br>**Pneumococcal conjugate.** At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.<br>**Hepatitis A.** Either of the following on or before the child's second birthday meet criteria:<br>• At least one hepatitis A vaccination, with a date of service on or before the child's second birthday.<br>• History of hepatitis A illness. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Childhood Immunization Status (continued from previous page) | | | | **Rotavirus.** Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.<br>• At least two doses of the two-dose rotavirus vaccine on different dates of service.<br>• At least three doses of the three-dose rotavirus vaccine on different dates of service.<br>• At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine, all on different dates of service.<br>**Influenza.** At least two influenza vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to six months (180 days) after birth.<br>**Combination rates.** Refer to *HEDIS® 2015 Volume 2 Technical Specifications for Health Plans* for full description of combination vaccinations 2-10. |
| Developmental Screening in the First Three Years of Life | The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age. | NCQA | Children in the eligible population who turned 1, 2 or 3 during the measurement year. | Children in the entire eligible population who had claim with CPT code 96110 in the 12 months preceding their 1st, 2nd, or 3rd birthday.<br>**Claims data.** CPT code 96110 (Developmental testing, with interpretation and report)<br>See *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), July 2014,* for appropriate use of claims data information (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf) |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Follow-up Care for Children Prescribed ADHD Medication ($$) | The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10- month period, one of which was within 30 days of when the first ADHD medication was dispensed. | NCQA | **Initiation Phase.** Members who turned 6 years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year. Members in the specified age range who were dispensed an ADHD medication during the 12-month Intake Period. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.<br>**C&M Phase.** Members who meet the eligibility criteria for the Initiation Phase and filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSD. Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD. | **Initiation Phase.** An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD.<br>**C&M Phase.** Identify all members who meet the following criteria:<br>• Numerator compliant for Rate 1—Initiation Phase, and<br>• At least two follow-up visits from 31–300 days (9 months) after the IPSD with any practitioner.<br>One of the two visits (during days 31–300) may be a telephone visit with any practitioner. |
| Human Papillomavirus (HPV) Vaccine for Female Adolescents | Percentage of female adolescents that turned 13 years old during the measurement year and had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. | NCQA | Female adolescents who turn 13 years of age during the measurement year. | At least three HPV vaccinations, with different dates of service on or between the member's 9th and 13th birthdays. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Immunization Status for Adolescents | The percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday. | NCQA | Adolescents who turn 13 years of age during the measurement year. | **Meningococcal**. At least one meningococcal conjugate or meningococcal polysaccharide vaccine, with a date of service on or between the member's 11th and 13th birthdays.<br>**Tdap/Td.** Any of the following with a date of service on or between the member's 10th and 13th birthdays meet criteria:<br>• At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine.<br>• At least one tetanus, diphtheria toxoids (Td) vaccine.<br>• At least one tetanus vaccine and at least one diphtheria vaccine on the same date of service or on different dates of service.<br>**Combination 1 (Meningococcal, Tdap/Td)**. Adolescents who are numerator compliant for both indicators (meningococcal, Tdap/Td).<br>For meningococcal and Tdap or Td, count only evidence of the antigen or combination vaccine. |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: BMI for Children/ Adolescents | The percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner, with evidence of :<br>• BMI percentile documentation<br>• Counseling for nutrition<br>• Counseling for physical activity | NCQA | Members 3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators:<br>• 3–11 years.<br>• 12–17 years.<br>• Total.<br>The total is the sum of the age stratifications. | **BMI Percentile.** BMI percentile (BMI Percentile Value Set) during the measurement year. For adolescents 16–17 years of age on the date of service, a BMI value (BMI Value Set) also meets criteria.<br>**Counseling for nutrition.** (Nutrition Counseling Value Set) during the measurement year.<br>**Counseling for Physical Activity.** Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year. |
| Well-Child Visits in the First Fifteen Months of Life | The percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported. | NCQA | Members who turn 15 months old during the measurement year. | Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits, on different dates of service, with a PCP during their first 15 months of life. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life | The percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year. | NCQA | Members 3–6 years as of December 31 of the measurement year. | At least one well-child visit with a PCP during the measurement year. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. |
| Annual Monitoring for Patients on Persistent Medications | The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate. | NCQA | Members 18 years and older as of December 31 of the measurement year, who are on persistent medications (i.e., members who received at least 180 treatment days of ambulatory medication in the measurement year). | **ACE Inhibitors or ARBs.** At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:<br>• A lab panel test.<br>• A serum potassium test and a serum creatinine test.<br>**Digoxin.** At least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:<br>• A lab panel test and a serum digoxin test.<br>• A serum potassium test and a serum creatinine test and a serum digoxin test.<br>**Diuretics.** At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:<br>• A lab panel test.<br>• A serum potassium test and a serum creatinine test. |
| Comprehensive Diabetes Care: Hemoglobin A1c testing | The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year. | NCQA | Members 18–75 years as of December 31 of the measurement year identified as having diabetes. | An HbA1c test performed during the measurement year as identified by administrative data or medical record review. At a minimum, documentation in the medical record must include a note indicating the date on which the HbA1c test was performed and the result. The organization may count notation of the following in the medical record.<br>• A1c<br>• HbA1c<br>• Hemoglobin A1c<br>• Glycohemoglobin A1c |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Controlling High Blood Pressure | The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year. Three numerators are summed to produce one reported rate. | NCQA | Member 18–85 years as of December 31 of the measurement year and identified as hypertensive, i.e. if there is at least one outpatient visit with a diagnosis of hypertension during the first six months of the measurement year. | The number of patients in the denominator whose most recent, representative BP is adequately controlled during the measurement year. Adequate control is defined as meeting any of the following criteria:<br>• Members 18–59 years of age whose BP was <140/90 mm Hg.<br>• Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.<br>• Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. |
| Heart Failure Admission Rate | The number of discharges for heart failure per 100,000 member months for Medicaid enrollees age 18 and older (reported by Recipient Parish) | AHRQ | Total number of months of Medicaid enrollment for enrollees age 18 and older during the measurement year. | All discharges with ICD-9-CM principal diagnosis code for heart failure. |
| HIV Viral Load Suppression ($$) | The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200. | HRSA HIV/AIDS Bureau | Number of members, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year. | Number of members in the denominator with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. |
| Diabetes Short-Term Complications Admission Rate ($$) | The number of discharges for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 member months for Medicaid enrollees age 18 and older. | AHRQ | Total number of months of Medicaid enrollment for enrollees age 18 and older during the measurement year. | All discharges with ICD-9-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma). |
| Antenatal Steroids | This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. | TJC | Members delivering live preterm newborns with >=24 and <32 weeks gestation completed. | Members with antenatal steroid therapy initiated prior to delivering preterm newborns. |
| Elective Delivery | This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. | TJC | Members delivering newborns with >= 37 and < 39 weeks of gestation completed. | Members with elective deliveries. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Adherence to Antipsychotic Medications for Individuals with Schizophrenia | The measure calculates the percentage of individuals 19 years of age or greater as of the beginning of the measurement year with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement year (12 consecutive months). | CMS | Medicaid members 19 to 64 years of age as of December 31 of the measurement year with schizophrenia. | The number of members who achieved a proportion of days covered (PDC) of at least 80 percent for their antipsychotic medications during the measurement year. |
| Adult BMI Assessment | The percentage of members 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year. | NCQA | Members 18-74 of age who had an outpatient visit. | Body mass index documented during the measurement year or the year prior to the measurement year. |
| Ambulatory Care ($$) | Utilization of ambulatory care. Outpatient and ED Visits per 1000 member months | NCQA | For each product line and table, report all member months for the measurement year. Refer to *Specific Instructions for Utilization Tables* (HEDIS Volume 2, Guidelines for Utilization Measures) for more information. | **Outpatient visits.** Count multiple codes with the same practitioner on the same date of service as a single visit. Count visits with different practitioners separately (count visits with different providers on the same date of service as different visits). Report services without regard to practitioner type, training or licensing.<br>**ED visits.** Count each visit to an ED that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:<br>• An ED visit.<br>• A procedure code with an ED place of service code. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Antidepressant Medication Management | The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. | NCQA | Members 18 years and older as of April 30 of the measurement year, with a dispensing event for an antidepressant medication during the Intake Period.<br>Members who meet any of the following criteria remain in the eligible population:<br>• An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression.<br>• An ED visit with any diagnosis of major depression.<br>• An inpatient (acute or nonacute) encounter with any diagnosis of major depression.<br>Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD. | **Effective Acute Phase Treatment.** At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).<br>**Effective Continuation Phase Treatment.** At least 180 days (6 months) of continuous treatment with antidepressant medication during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 51 gap days. Count any combination of gaps (e.g., two washout gaps of 25 days each, or two washout gaps of 10 days each and one treatment gap of 10 days). |
| Asthma in Younger Adults Admission Rate | Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39. | AHRQ | Total number of months of Medicaid enrollment for enrollees ages 18 to 39 during the measurement year. | All non-maternal discharges for enrollees ages 18 to 39 with an ICD-9-CM principal diagnosis code of asthma. |
| Asthma Medication Ratio | The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. | NCQA | Members 5-64 years of age identified as having persistent asthma | Members in the denominator with a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Care Transition - Transition Record Transmitted to Health Care Professional | The percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge | AMA-PCPI | All members, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care | Members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. |
| Cervical Cancer Screening | The percentage of women 21–64 years of age who were screened for cervical cancer | NCQA | Women 24–64 years as of December 31 of the measurement year. | Identify women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year.<br>Women 30–64 years of age as of December 31 of the measurement year who had cervical cytology and a human papillomavirus (HPV) test with service dates four or less days apart during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the measurement year, then the HPV test must include a service date on or between December 1 and December 5 of the measurement year. |
| COPD or Asthma in Older Adults Admission Rate | The number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older. | AHRQ | Total number of months of Medicaid enrollment for enrollees age 40 and older during the measurement year. | All non-maternal discharges with an ICD-9-CM principal diagnosis code for:<br>• COPD or<br>• Asthma or<br>• Acute bronchitis and any secondary ICD-9-CM diagnosis codes for COPD |
| Flu Vaccinations for Adults Ages 18 to 64 | The percentage of commercial and Medicaid members 18–64 years of age who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H survey was completed. | NCQA | This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2015, Volume 3: Specifications for Survey Measures*. | |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Follow up After Hospitalization for Mental Illness | The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported (as indicated in numerator; 30 day follow-up and 7 day follow-up). | NCQA | Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year. | **30-Day Follow-Up.** An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.<br>**7-Day Follow-Up.** An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.<br>Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | The percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following:<br>• Initiation of AOD treatment.<br>• Engagement of AOD treatment. | NCQA | Members 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators. | **Initiation of AOD Dependence Treatment.** Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.<br>**Engagement of AOD Treatment.** Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). |
| Medical Assistance With Smoking and Tobacco Use Cessation | Assesses different facets of providing medical assistance with smoking and tobacco use cessation | NCQA | This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2015, Volume 3: Specifications for Survey Measures*. | |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
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| Medication Management for People with Asthma | The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. | NCQA | Members 5–64 years by December 31 of the measurement year as having persistent asthma, i.e.<br>• At least one ED visit, with a principal diagnosis of asthma.<br>• At least one acute inpatient encounter, with a principal diagnosis of asthma.<br>• At least four outpatient visits or observation visits, on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events. Visit type need not be the same for the four visits.<br>• At least four asthma medication dispensing events.<br>Or a member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier (i.e., the measurement year or the year prior to the measurement year). | **Medication Compliance 50%.** The number of members who achieved a PDC of at least 50% for their asthma controller medications during the measurement year.<br>**Medication Compliance 75%.** The number of members who achieved a PDC of at least 75% for their asthma controller medications during the measurement year. |
| Plan All-Cause Readmission Rate | For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. | NCQA | Count the number of Index Hospital Stays for each age, gender, and total combination. | Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
|---|---|---|---|---|
| Screening for Clinical Depression and Follow-Up Plan | The percentage of patients aged 18 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented. | CMS | Members 18 years and older who had an outpatient visit during the measurement year | Members screened for clinical depression using a standardized tool, and if positive, a follow-up plan is documented on the date of the positive screen using one of the clinical depression screening codes. |
| Call Answer Timeliness | The percentage of calls received by the organization's Member Services call centers (during operating hours) during the performance measurement year that were answered by a live voice within 30 seconds. | NCQA | Refer to *HEDIS® 2015 Volume 2 Technical Specifications for Health Plans* for full description. | Refer to *HEDIS® 2015 Volume 2 Technical Specifications for Health Plans* for full description. |
| Ambulatory Care-Sensitive Condition Admission | Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care may prevent or reduce the need for admission to hospital, per 100,000 population. | CIHI | Total mid-year population under age 75, per 100,000 (age adjusted). | Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years. |
| Chlamydia Screening in Women | The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year. | NCQA | Women 16–24 years as of December 31 of the measurement year identified as sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.<br>**Claim/encounter data.** Members who had a claim or encounter indicating sexual activity during the measurement year.<br>**Pharmacy data.** Members who were dispensed prescription contraceptives during the measurement year. | At least one Chlamydia test during the measurement year. |

| Measure | Measure Description | Measure Steward | Denominator | Numerator |
|---|---|---|---|---|
| Breast Cancer Screening | Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer. | NCQA | Women 52–74 years as of December 31 of the measurement year. | One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year. |

* Specifications for this measure may be modified based on available data
$$:  Indicates an incentive-based measure

## Administrative Measures

The following are state-specific process measures that are calculated using the administrative methodology:

| Measure | Minimal Performance Standard |
|---|---|
| % of PCP practices that provide verified 24/7 phone access with ability to speak with a PCP practice clinician (MD, DO, NP, PA, RN, LPN) within 30 minutes of member contact | ≥95% |
| % of regular service authorization requests processed in timeframes in the contract | ≥80% |
| % of expedited service authorization requests processed in the timeframes in the contract | ≥99% |
| Rejected claims returned to provider with reason code within 15 days of receipt of claims submission | ≥99% |
| % of call center calls answered within 30 seconds | ≤95% |
| Call center average speed of answer | 30 seconds |
| Call center call abandonment rate | ≤5% |
| % of grievances and request for appeals received by the MCO including grievances received via telephone and resolved within the timeframe of the contract | ≥95% |
| % of clean claims paid for each provider type with 15 business days | ≥90% |
| % of clean claims paid for each provider type within 30 calendar days | ≥99% |